

\$306

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-024678

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

6731

FILED JUL 12 1962

VS 300  
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Charles	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		c. CITY OR TOWN St. Charles	
c. FULL NAME OF DECEASED BARNES HOSPITAL		d. STREET ADDRESS (If outside, give location) 428 Houston Ave.	
3. NAME OF DECEASED (Type or print) First MARIÉ Middle ELIZABETH Last GRAY		4. DATE OF DEATH Month JULY Day 8 Year 1962	
5. SEX Female	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1-3-1903
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		9b. KIND OF BUSINESS OR INDUSTRY home	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	
11a. FATHER'S NAME John Rose		11b. MOTHER'S MAIDEN NAME Catherine Venemann	
12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		12b. SOCIAL SECURITY NO. [REDACTED]	
13a. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LEFT BREAST WITH METASTASES		13b. INTERVAL BETWEEN ONSET AND DEATH SEVERAL MOS	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 170X DUE TO (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from JUNE 2, 1962 to JULY 8, 1962 and last saw her alive on JULY 8, 1962		Death occurred at 9:20 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE E.O. Vermillion, M.D. (Degree or title)		22b. ADDRESS BARNES HOSPITAL	
22c. DATE SIGNED 7/8/62		22d. LOCATION (City, town, or county) (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 7-8-62	
23c. NAME OF CEMETERY OR CREMATORY ST. PETERS CEM.		23d. LOCATION (City, town, or county) (State) ST. CHARLES, MO.	
24. FUNERAL DIRECTOR PRINSTER BAUER F.H. INC. ST. CHARLES		25. DATE RECD. BY LOCAL REG. JUL 8 1962	
26. REGISTRAR'S SIGNATURE Carl Smith, M.D.			

USE BLACK INK

OR TYPEWRITER RIBBON

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Frederic N. Bone

Licensed Embalmer No. 4607

P. O. Address St. Charles, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.